TESTIMONY OF

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Solving the Small Business Health Care Crisis:
Alternatives for Lowering Costs and Covering the Uninsured

Before the Senate Committee on Small Business

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Good morning Chairwoman Snowe, Ranking Member Kerry, members of the committee. My name is William Lindsay and I am here as the former Chair of the National Small Business Association. NSBA is the nation's oldest nonpartisan small business advocacy group reaching more than 150,000 small businesses nation-wide. I have spent my career running a small business whose mission was to help other businesses with selecting appropriate benefits packages. As both a small business owner and expert in the health care insurance field, I thank you for this opportunity to speak with you today.

As we all know, small businesses are being pummeled by the increasing cost of health care. Health care consistently ranks among the top concerns of our members and during NSBA's 2005 Small Business Congress, out of our top-5 voted-on priority issues, 3 deal with health care. As members of this fine committee, I am sure you hear on a daily basis the need for some small business relief in the form of small group insurance market reform. NSBA would agree that something must be done to alleviate this burgeoning burden small businesses face. We believe that, while targeted reforms will help, a comprehensive solution must be sought rather than placing a series of too-small band-aids on a problem that looks an awful lot like a broken leg.

Oppose Association Health Plans

There have been calls from various national small business groups to create Association Health Plans (AHPs). The push for AHPs are a reaction to the very dire circumstances small businesses currently face in the health insurance arena: huge premium increases, a lack of control and clout, the costly tangle of state and federal regulations, and fewer funding, carrier, and plan selection options than their larger counterparts.

Despite those good intentions, we are concerned that AHPs are not only a non-answer to the real issues driving cost, but will exacerbate the problems small businesses face. The primary focus and cost savings of AHPs is through circumventing state laws and rating rules. AHPs threaten to greatly worsen the market segmentation and risk-aversion that currently characterize the small group health insurance market, which are at the root of the health care crisis uniquely faced by smaller firms. AHPs might be good for small business associations (like NSBA) who want to run them, but NSBA believes that they will not be good for the small business community at-large, whose interests we are bound to represent.

Bigger is Better?

One of the fundamental precepts that underpins the arguments of those advocating for AHPs is the idea that big pools will equal bargaining clout. In almost every market in the world, the larger the quantity you buy of something, the lower its per-unit price. In the health insurance market, however, the make-up and location of that pool are both far more important factors in establishing a price than size alone.

A pool of 1,000 people with an average age of 40 could demand (and receive) a much better rate than a pool of 50,000 people with an average age of 55. Moreover, when a plan is negotiating reimbursement with providers, a local hospital or physician will be driven by how many patients the plan will bring them. A local plan with a total of 100,000 lives will be able to drive a much better deal than a big national plan with 5 million lives, only 15,000 of which are local.

The risk profile of the group and their geographic concentration are the two most important factors in negotiating rates for small business health insurance. Unfortunately, AHPs create significant problems on both fronts.

Risk Selection

The insurance industry competes based largely upon each company's ability to attract better risks (i.e. healthier people). AHPs are likely to function in the same way. While AHPs could not exclude any specific qualified association member, risk selection is a much more subtle and powerful phenomenon than such blatant discrimination alone. In fact, such selection would be the crux of AHPs' competitive advantage, reaped though benefit manipulation and rates charged.

By carefully designing benefit packages that will be relatively unattractive to older and less-healthy populations, AHPs will be able to simultaneously attract a higher proportion of younger and healthier individuals in their pools, thereby driving down their expected claims costs and, thus, their premiums. According to a June 2003 study by Mercer Risk, Finance and Insurance, the "morbidity" (measure of a firm's overall sickness) of firms enrolling in AHPs would be 21 percent lower than the average small business, leading to a 12.3 percent increase in the morbidity rate of the uninsured.

Currently, the rates that can be charged in the small group market are regulated by the states. Most states have "rate bands" of varying degrees that define the window in which rates can fluctuate and on what basis they can fluctuate. Other states have a form of community rating in which rates are essentially the same for all participants. Self-insured AHPs would not have to use rate bands at all. If an AHP with a wide rate band (or no rate band) were to sell into a community-rated state, the consumer choices would be stark. The AHP rates for younger, healthier groups are likely to be significantly less while AHP rates for older, less-healthy groups are likely to be higher than the average rate in a community-rated state. It is easy to see what will happen: younger, healthier groups will join AHPs, and the rest will not. Of the horror stories we hear daily about premium hikes faced by small businesses, the most egregious examples (those who have seen rates go up by 70 percent or more in one year) are often from cases where the group has entered a higher age bracket. AHPs will make these situations even worse.

Since apportionment of health risk is ultimately a zero-sum game, lower premiums for those participating in AHPs will mean higher premiums elsewhere. These increases will drive more healthy people away from the traditional pools and into AHPs. Those AHPs that attract significantly better risks can be highly profitable. But AHPs that refuse to engage in this sort of risk selection, as well as traditional plans that are forbidden by state law from doing so, will fall

into what is known as a "death spiral," where higher premiums chase away better risks, which leads to still higher premiums. The end result will be the destruction of the traditional insurance market for small firms and the displacement of millions of currently insured individuals. The most effective way for such a pool to achieve lower premiums is to attract better risks. To deny that such will occur is to deny the effect of market forces.

Two types of associations seem most likely to offer AHPs: national vertical trade associations (representing a specific industry, e.g. banking, restaurants) and national general small business groups (such as NSBA or NFIB). A vertical trade group that believes that its trade population is relatively young and healthy is likely to start an AHP, and expect it to be successful. Similarly, a vertical trade group that believes its trade population is relatively old and unhealthy is unlikely to be able to sustain an AHP. In other words, affected trade associations and their health insurer partners would behave predictably and according to their organizations' financial interests. Risk selection would be part of AHPs from the very beginning. To believe otherwise is to refuse to acknowledge the way small group insurance markets function now, in spite of heavy state regulation.

It also is likely that there would be a number of national general small business AHPs. These associations would market nationally to potential members, largely on the basis of premium. Given that these groups would all have the same regulatory advantages, they would succeed or fail almost entirely on their ability to attract and maintain a healthier population.

Cost and Access

Proponents claim that AHPs will save their members significant amounts of money. In fact, a Congressional Budget Office (CBO) paper estimated that businesses switching from an existing state-regulated pool to an AHP would see their premiums decline by 13 percent, a fairly substantial savings. However, most (almost two-thirds) of those savings come from the risk selection described above. According to the CBO paper, AHPs would achieve cost savings by draining away healthier individuals from the state-regulated pools, thereby forcing premiums to go yet higher for the majority of the market. The CBO estimates costs will decline for the 20 percent of businesses that join AHPs, but will, therefore, go up for everyone else. That increase in costs will add to the already rising ranks of uninsured by more than one million if AHP legislation passed, according to the Mercer Report.

Proponents of AHPs hope that premium savings will cause new individuals to be insured. However, the CBO paper cited above clearly shows that the overwhelming number of participants in AHPs will be those who switched from a traditionally insured plan to an AHP. CBO believes that these switchers would outnumber the newly insured by nearly 14-to-1. We also must point out that the higher premiums for non-AHPs could lead to greater numbers of uninsured individuals, exactly the opposite of the outcome desired by proponents.

Proponents of AHPs say that associations will act in their members' best interests and avoid these practices. But, to serve their members and to attract new members, AHPs will have to keep premiums as low as possible.

Contrary to the rosy picture painted by proponents of AHPs, we fear this legislation would only serve to dig the small business health market even deeper into a hole of adverse selection, further distorting an already perverted market. Those who have the least need for health care services will be able to buy health insurance cheaply (and insurers and AHPs will find this business very profitable). But those who are at greatest risk of illness will be least able to afford coverage, and insurers will find ever-more creative ways to avoid selling coverage to those with greatest need.

AHPs may cause a number of currently uninsured Americans to get coverage. However, we believe that it will, over time, cause even more small business owners and employees to reduce and give up coverage due to cost increases.

If this hastened train-wreck is what occurs from AHPs, matters will not be politically or economically sustainable unless Congress embarks on exactly the kind of national mandate-setting and market regulation that all 50 states are struggling with right now (and which AHPs are a rebellion against). Some might think that would be a good thing, but one suspects that it would be very difficult to generate a majority for AHPs if it was understood this kind of additional federal intervention would be necessary in a few years.

NSBA's Comprehensive Solution

In attempting to create positive health care reform for small businesses, one quickly bumps up against the reality that the small business problems cannot be solved in isolation from the rest of the system. Since small businesses purchase insurance as part of a larger pool with shared costs, the decisions of others directly affect what a small business must pay and the terms on which insurance is available to them. It has become clear to NSBA that—to bring meaningful affordability, access, and equity in health care to small businesses and their employees—a broad reform of the health care system is necessary. This reform must reduce health care costs while improving quality, bring about a fair sharing of health care costs, and focus on the empowerment and responsibility of individual health care consumers.

The Realities of the Insurance Market

Small employers who purchase insurance face significantly higher premiums from at least two sources that have nothing to do with the underlying cost of health care. The first is the cost of "uncompensated care." These are the expenses health care providers incur for providing care to individuals without coverage; these costs get divided-up and passed on as increased costs to those who have insurance. This practice is known as "cost-shifting."

Second is the fact that millions of relatively healthy Americans choose not to purchase insurance (at least until they get older or sicker). Almost four million individuals aged 18-34 making more than $50,000 per year are uninsured. The absence of these individuals from the insurance pool means that premiums are higher for the rest of the pool than they would be otherwise. Moving these two groups

of individuals onto the insurance rolls would bring consequential premium reductions to current small business premiums.

Implicit in the concept of insurance is that those who use it are subsidized by those who do not. In most arenas, voluntary insurance is most efficient since the actions of those outside the insurance pool do not directly affect those within. If the home of someone without fire insurance burns down, those who are insured are not expected to finance a new house. Not so in the health arena. Moreover, individuals' ability to assess their own risk is somewhat unique regarding health insurance. People have a good sense of their own health, and healthier individuals are less likely to purchase insurance until they perceive they need it. As insurance becomes more expensive, this proclivity is further increased (which, of course, further decreases the likelihood of the healthy purchasing insurance).

Individual Responsibility

There is no hope of correcting these inequities until we have something close to universal participation of all individuals in some form of health care coverage. NSBA's plan for ensuring that all Americans have health coverage can be simply summarized: 1) require everyone to have coverage; 2) reform the insurance system so no one can be denied coverage and so costs are fairly spread; and 3) institute a system of subsidies, based upon family income, so that everyone can afford coverage.

Of course, the decision to require coverage would mean that there must be some definition of the insurance package that would satisfy this requirement. Such a package must be truly basic. The required basic package would include only necessary benefits and would recognize the need for higher deductibles for those able to afford them. The shape of the package would help return a greater share of health insurance to its role as a financial backstop, rather than a reimbursement mechanism for all expenses. More robust consumer behavior will surely follow.

Incumbent on any requirement to obtain coverage is the need to ensure that appropriate coverage is available to all. A coverage requirement would make insurers less risk averse, making broader insurance reform possible. Insurance standards would limit the ability of insurance companies to charge radically different prices to different populations and would eliminate the ability of insurers to deny or price coverage based upon health conditions, in both the group and individual markets. Further, individuals and families would receive federal financial assistance for health premiums, based upon income. The subsidies would be borne by society at large, rather than in the arbitrary way that cost-shifting currently allocates these expenses.

Finally, it should be clear that coverage could come from any source. Employer-based insurance, individual insurance, or an existing public program would all be acceptable means of demonstrating coverage.

Reshaping Incentives

There currently is an open-ended tax exclusion for employer-provided health coverage for both the employer and employee. This tax status has made health insurance preferable to other forms of compensation, leading many Americans to be "over-insured." This over-insurance leads to a lack of consumer behavior, increased utilization of the system, and significant increases in the aggregate cost of health care. Insurance now frequently covers (on a tax-free basis) non-medically necessary services, which would otherwise be highly responsive to market forces.

The health insurance tax exclusion also creates equity concerns for small employers and their employees. Since larger firms have greater access to health insurance plans than their smaller counterparts, a greater share of their total employee compensation package is exempt from taxation. Further, more small business employees are currently in the individual insurance market, where only those premiums that exceed 7.5 percent of income are deductible.

For these reasons, the individual tax exclusion for health insurance coverage should be limited to the value of the basic benefits package. But this exclusion (deduction) also should be extended to individuals purchasing insurance on their own. Moreover, the tax status of health insurance premiums and actual health care expenses should be comparable. These changes would bring equity to small employers and their employees, induce much greater consumer behavior, and reduce overall health care expenses.

Reducing Costs by Increasing Quality and Accountability

While the above steps alone would create a much more rational health insurance system, a more fair financing structure, and clear incentives for consumer-based accountability, more must be done to rein-in the greatest drivers of unnecessary health care costs: waste and inefficiency. Increased consumer behavior can help reduce utilization at the front end, but most health care costs are eaten up in hospitals and by chronic conditions whose individual costs far exceed what any normal deductible level.

There is an enormous array of financial pressures and incentives that act upon the health-care provider community. Too often, the incentive for keeping patients healthy is not one of them. Our medical malpractice system is at least partly to blame. While some believe these laws improve health care quality by severely punishing those who make mistakes that harm patients, the reality is that they simply lead to those mistakes—and much more—being hidden.

Is it any wonder that it is practically impossible to obtain useful data on which to make a provider decision? Which physician has the best success-rates for angioplasty procedures? Which hospital has the lowest rate of staph infections? We just don't know, and that lack of knowledge makes consumer-directed improvements in health care quality almost impossible to achieve.

Health care quality is enormously important, not only for its own sake, but because lack of quality adds billions to our annual health care costs. Medical errors, hospital-acquired infections, and other forms of waste and inefficiency cause additional hospital re-admissions, longer recovery times,

missed work and compensation, and death. The medical costs alone probably total into the hundreds of billions of dollars.

What financial pressures are we bringing to bear on the provider community to improve quality and reduce waste? Almost none. In fact, we may be doing the opposite, since providers make yet more money from re-admissions and longer-term treatments. It is imperative to reduce costs through improved health care quality. Rather than continuing to pay billions for care that actually hurts people and leads to more costs, we should pay more for quality care and less (or nothing) when egregious mistakes occur.

Two broad reforms are urgent:
Pay-for-Performance. Insurers should reimburse providers based upon actual health outcomes and standards, rather than procedures. In some pilots, CMS and Medicare have already begun this process. Evidence-based indicators and protocols should be developed to help insurers, employers, and individuals hold providers accountable. These protocols—if followed—could also provide a level of provider defense against malpractice claims.

Electronic Records and Procedures. From digital prescription writing to individual electronic medical records to universal physician IDs, technology can reduce unnecessary procedures, reduce medical errors, increase efficiency, and improve the quality of care. This data also can form the basis for publicly available health information about each health care provider so that patients can make informed choices.

Substantial cost containment is embodied in the NSBA Health Policy outlined above. Limits on the tax exclusion will drive individuals to become less dependent upon third-party payers in their medical transactions. More of a consumer-based market will develop for routine medical care, thereby putting downward pressure on both prices and utilization. Through both increased consumer awareness and specific quality-control methods, costs can be reined in and small businesses can get back to doing what they do best rather than searching for affordable health care: creating jobs.

Targeted Solutions

While we would argue that a comprehensive policy is truly the way to fix the health care market, we do realize that our plan is aggressive and would likely not happen over-night. In the mean-time, NSBA would support a series of more targeted solutions to provide some relief to small businesses and their employees.

After several years of relative stability on the health care front, the patch-work of 1990s reforms have begun to fray and come apart. Small employers are once again facing annual double-digit increases, the cost, control, and quality improvement promises of managed care have fallen short, and Congress is once again considering legislation that will make the situation far worse. To

compound matters, the recent recessionary environment ballooned the number of uninsured to a staggering 45 million.

Nearly every substantial reform that Congress has enacted on health care during the last decade has driven up health care costs and insurance premiums. Medicare reforms, insurance market reforms, mental health parity revisions—all have responded to some real problem, but they have all piled on new costs or shifted costs to the private sector. That being said, NSBA would like to highlight the important reforms made to Medical Savings Accounts through the creation of Health Savings Accounts (HSAs). HSAs respond to unfairness in our tax policy, and they also generate a level of "consumer behavior" that can provide a significant component of an over-all market-based cost containment strategy. However the creation of HSAs is just the beginning of many smaller, more targeted reforms that need to be addressed.

Expansion of HSAs

HSAs are tax-free savings accounts that people can set up when they purchase a high-deductible policy to cover major medical expenses. Money from the HSA can be used to pay for routine medical expenses or saved for future health needs, while the major medical policy helps cover big expenses, like hospital stays. Unlike MSAs, however, HSAs allow for both employer and employee annual contributions and unused funds to rollover. Individuals with an HSA can contribute up to 100 percent of the annual deductible of their health insurance program. HSAs also have lower minimum required deductible and out-of-pocket limits. Perhaps one of the most important changes from MSAs to HSAs is the fact that anyone can participate, there are no longer restrictive limits on the program.

While HSAs have been available for a little more than one year, there are still further actions Congress should take to expand the program. Individuals participating in an HSA should be allowed to deduct the premiums for the high-deductible health insurance policies from their taxable income in conjunction with an HSA. Increasing the tax benefit to these plans will increase affordability. NSBA also would support President Bush's proposal to help individuals and families who work for small businesses fund their HSAs. Under the proposal, small business owners would receive a tax credit on HSA contributions for the first $500 per worker with family coverage and the first $200 per worker with individual coverage.

Pool Small Businesses Locally

Encourage the development of local employer health care coalitions that would assist small employers in obtaining lower rates for coverage through group purchasing. Such coalitions also would assist small employers in learning about existing local health insurance plan options, how to be a wise health insurance purchaser, the issues of health care costs, health care quality and the availability of health care providers within their communities. Such local employer health care coalitions would continue to be subject to their respective state laws. Therefore, there would continue to be a level playing field for all employers providing insurance in the small employer market. These coalitions already exist in many states, providing choice and savings for their members every day

Reform HRAs and FSAs

In 2002, Bush highlighted Health Reimbursement Accounts (HRAs) which are similar to MSAs, but can only accept employer contributions, and employees cannot keep their excess funds. Though HSAs and HRAs are somewhat similar, HRA reform would also help those individuals seeking a low-deductible plan but would also like a savings account to help pay for medical costs. Reforming the HRA structure includes: allowing employees to contribute, allowing employees to roll excess funds into retirement plans, and, most importantly, allowing small business owners to participate. Like so-called cafeteria plans, HRAs specifically exclude owners of non-C Corporations from participating. This is a major obstacle that must be overcome if small companies are ever to take advantage of the potential of these plans.

On the subject of cafeteria plans (Section 125 plans), it should be noted that reforms of these plans also could be an important factor in increasing the ability of small business employees to fund various kinds of non-reimbursed care. Two major roadblocks are in the way. First, small business owners generally cannot participate in cafeteria plans. Second, these plans have annual "use-it-or-lose-it" provisions, which cause some to spend money that did not need to be spent, but cause many more to never contribute to the plan in the first place. Fixing these two mistakes would be a real benefit to small business employees struggling to meet their out-of-pocket medical bills.

Create Health Insurance Tax Equity

After 16 years of struggle and unfairness, small business owners were finally able to deduct all of their health insurance expenses against their income taxes in 2003. Unfortunately, we are still only part-way to real health insurance tax equity for small business. Except for business owners, workers are allowed to treat their contributions to health insurance premiums as "pre-tax." This distinction means that those premium payments are subject neither to income taxes, nor to FICA taxes. While the owner of a non-C Corporation can now deduct the full premium against income taxes, that entire premium is paid after FICA taxes. Compounding matters, these business owners pay both halves of the FICA taxes on their own income for a total Self Employment tax burden of 15.3 percent.

Right here in Washington, D.C., the cost of a Blue Cross/Blue Shield family policy in a small group plan has topped $12,000 per year. A business owner who makes $60,000 and purchases this plan for his or her family pays $2,000 in taxes on that policy. A worker who makes $60,000 and has the same plan pays nothing in taxes on that policy. By treating this business owner the same way that everyone else in this country is treated, we can give him or her a 15 percent discount on health insurance premiums.

Reform the Medical Liability System

The enormous costs of medical liability and the attending malpractice insurance premiums are a significant factor pushing health care costs higher and restricting choice and competition for

consumers of health care. Triple-digit increases in malpractice premiums over the last five years have been common in many states and specialties.

These costs have a distorting effect on the health care system by causing physicians to retire early, change their practices to serve lower-risk patients, move to states with reformed malpractice laws, and concentrate their practice in high-profit centers, making quality health in rural areas and smaller towns increasingly difficult to come by. All of these changes restrict competition and the ability of employers to negotiate lower reimbursement rates. But the most profound affect of the liability system is the "defensive medicine" that is practiced by many risk-averse providers. Unnecessary, purely defensive procedures, cost the health care system untold billions each year and drive up premiums for all of us.

Legislation introduced in the 108th Congress would have capped non-economic damages at $250,000. While many supported this, the legislation was stalemated in the Senate. In the 109th already, however the Senate GOP leadership has placed medical malpractice as one of their top priorities and the outlook is better than it was in the 108th. NSBA supports the elimination of junk lawsuits and reasonable caps as a means to slow the increasing costs we all pay.

Pay-for-Performance

NSBA is a strong advocate for pay-for-performance initiatives. One of the biggest usurpers of health care dollars is due to poor quality leading to further complications and cost. Quality health care is a major factor in reducing the cost of care, and providers must be compensated accordingly. The implementation of a third-party payer system has removed levels of accountability from all sectors of the current health care market where individuals, health providers and insurance companies have very different interests at heart. Individuals want ease and affordability, take very little responsibility in their care and do not generally make educated choices in terms of providers, procedures and costs.

NSBA strongly supports the Centers for Medicare and Medicaid Services (CMS) new pay for performance policy change. CMS has taken a lead in implementing policy changes that will increase the importance of quality care. Through their reimbursements, CMS will now be requiring hospitals to comply with certain quality standards. Those that do not will see a small percentage of their reimbursements withheld. This kind of thorough evaluating and monitoring of care is necessary in providing patients with the highest quality care possible.

Improvements in Technology

Improved and standardized technology is necessary to gauge provider quality and ensure simple mistakes are not made as rampantly. Individuals should all have a privately owned, portable electronic health record. This would enable individuals and their doctors to access the record without having to wrangle a massive paper trail.

The system currently used for prescriptions also is outdated. NSBA would urge the use of technological devices when issuing prescriptions in order to avoid costly and dangerous mistakes.

The medical industry will need to establish a set of protocols by which doctors, hospitals and other care-givers can be evaluated. Improved technology will help providers report on their compliance with these protocols. Such information should be made widely available to the consumers of health care.

Protect the Small Employer Health Market from Gamesmanship

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 ensured that small groups could not be denied coverage by any insurer offering small group coverage in their state. The federal law, however, does not ensure that this coverage would be affordable, though states generally have implemented "rate bands" that provide some upper limit on rate increases for particular groups.

The individual market, however, is generally free of the guaranteed issue requirements enacted by HIPAA. Only those who had other insurance within the previous six months would be free of exclusion. This difference in rules between the individual market and the small group market means that premiums for younger and healthier individuals are almost always lower in the individual market than in the small group market. The opposite is generally true for older and less healthy individuals: their premiums are less in the small group market than in the individual market. This dynamic understandably leads some employers to purchase less expensive individual coverage on behalf of their employees, when they can qualify for low rates. When significant illness occurs, the individual premium escalates sharply, and the business will often switch to a small group plan, where they must be accepted and where the premiums will be much lower.

While this entire process is perfectly rational from the employer's perspective, it forces small group premiums to be higher than they otherwise would be. We believe that premiums would be lower and overall access to health insurance higher if this practice were discouraged, perhaps through a surcharge when the business re-enters the small group market (much like the penalty for early withdrawal of IRAs). Another way would be to clarify that employer-paid premiums in the individual market are taxable to the employee.

Help the Uninsured through Tax Credits and Current Programs

Much of the question of adequate health insurance coverage is really a question of affordability. There is probably no more efficient way to provide public subsidies for health insurance than through a system of tax credits, scaled to income, and targeted at individuals, such as those proposals that the President has put on the table. Further expansions of Medicaid and SCHIP programs to serve uninsured populations should also be considered.

It is NSBA's philosophy that, while these piecemeal changes will have a very positive effect on small businesses, there ought to be a long term health market reform movement. A health care system that embraces individual choice, consumerism, recognition for quality services and affordability is paramount.

I would like to again thank you Chairwoman Snowe, Ranking Member Kerry for this great opportunity to speak with you on such an important and timely subject.